Executive Summary

The Oregon Health Plan (OHP) is Oregon's innovative Section 1115 Medicaid waiver program. OHP has garnered national attention for its use of a prioritized list of health care services to define the program's benefit package. In addition, OHP expanded eligibility to cover uninsured residents below the Federal Poverty Level (FPL), regardless of whether they meet traditional categorical Medicaid eligibility requirements. Funding for this expansion has come, in part, by moving nearly all OHP eligibles into capitated managed care plans.

This report presents selected analyses conducted as part of our HCFA-funded evaluation of OHP. While the report focuses largely on OHP's Phase 1 population (traditional ADC plus expansion eligibles), future reports also will examine the Phase 2 population: SSI disabled and dual Medicare eligibles.

Update on the Oregon Health Plan

Higher than expected costs have meant that OHP has had to seek new ways to finance care. While one rationale for the priority list was as a tool for budgetary control, it has not yet served this end as well as some in the State had hoped. Restricting the list has been cumbersome because of approval requirements at the State and Federal levels. The most recent (1997) revision to the priority list both added two new treatment-condition pairs to the existing list of 741 and changed their ranking. This resulted in a funding line of 574 (as opposed to 578 on the 1995 list), and HCFA refused to approve the new list until May 1998.

Like other states, Oregon has turned to tobacco tax revenues to support its expanded Medicaid program. A new 30-cent tax was passed overwhelmingly to support OHP, and will be used for the following:

- Expand the PLM program to cover pregnant women up to 170 percent of FPL;
- Re-extend coverage to uninsured Pell Grant college students who had lost coverage as the result of an earlier OHP budget shortfall; and
- Create the Family Health Insurance Assistance Program (FHIAP) to subsidize private insurance premiums for low-income adults and children.

The newest source of revenue for OHP will come from the State Children's Insurance Program (CHIP). Oregon's share is $39.1 million annually. The State's plan (which was approved by HCFA in June 1998) will provide coverage for children up to age 18 who live in households with incomes from 100 to 170 percent of FPL.

Using Premiums to Finance OHP for the Expansion Population

OHP's expansion population is required to pay monthly premiums based on a sliding scale, determined by income and family size. Waivers are available for those unable to pay, and have been granted to about 3 percent of households (usually because the family reported zero income). The majority of expansion households appear willing and able to make the premium payments, with 66 percent of billed premiums collected from two-thirds of all households.

Expansion eligibles who fail to pay their monthly premium bills are carried in arrears for the entire six-month eligibility period, rather than being terminated immediately. Upon re-application, however, eligibles will be denied coverage if premium payments are not up to date. A relatively small number of such individuals are terminated for non-payment: about 1,000 individuals living in 700 households out of the 79,000 households billed each month.

It is not clear how many expansion eligibles fail to re-apply, either because they can not continue to make the premium payments or because they are in arrears (and know they will be denied anyway). Anecdotal evidence suggests that some, particularly single adults and childless couples, do not re-apply because the illness that precipitated their initial application to OHP has been resolved.

Paying Providers in a Capitated Medicaid Managed Care Program: Lessons from OHP

State administrators originally designed OHP's rate setting system to ensure that capitation rates would adequately cover the expected costs of treating various eligibility groups. In particular, the system was designed to discourage adverse selection by paying out higher reimbursement rates for OHP beneficiaries who belong to more expensive eligibility groups. OHP has faced several challenges in setting capitation rates, however. First, the State has had to refine its rate categories to more accurately reflect costs incurred by different groups. Initially, expansion eligibles were combined for rate purposes with traditional Medicaid eligibles. These eligibility groups proved to be very heterogenous with respect to

utilization, however, and eventually OHP divided this single rate group into five separate groups.

The availability of accurate data for setting rates has also been an obstacle. The New Adults/Couples expansion population was assumed to resemble a commercially insured population and the actuaries used Blue Cross/Blue Shield of Oregon claims to help set their capitation rates. However, this group proved to be far more expensive, as they often first became eligible during a hospitalization. The data used to calculate rates for traditional Medicaid and New Families eligibles have also become increasingly inaccurate. Actuaries at OMAP initially used pre-OHP Medicaid fee-for-service claims to set rates for these eligibility groups. Yet, as an increasing number of eligibles become enrolled in managed care, what fee-for-service claims remain become increasingly non-representative.

To develop a more accurate base for determining capitation rates, OMAP has made a concerted effort to employ encounter data submitted by the participating health plans as the basis for future capitation rate determinations. Undermining these efforts have been concerns about the quality of the encounter data being submitted to OMAP. Specifically, earlier analyses of the data indicated that reporting on encounters varied significantly in terms of accuracy and completeness. More recent data submissions, however, show a dramatic increase in reporting. As a result, OHP actuaries began using encounter data to risk adjust capitation rates for certain eligibility groups as of June 1, 1998.

Managed Care Contracting in OHP: Market Consolidation and Delivery System Impacts

OHP has succeeded in creating a statewide managed care delivery system, with contracting plans in all but two of Oregon's 36 counties. Local, physician-sponsored plans have emerged as increasingly important, particularly in rural areas. These plans reflect an effort by providers to retain local control over service delivery decisions and to resist the intrusion of centrally-organized, statewide managed care plans. The growing importance of these locally sponsored plans, along with the departure of several commercial plans has increased OHP's reliance on "non-mainstream" plans that either were initially formed to contract with OHP or enroll only Medicaid eligibles.

However, several of these OHP-only plans are either considering or have already branched into the Medicare and commercial markets. Balanced Budget Act provisions that permit contracting with provider-sponsored networks should further encourage expansion of OHP into these new markets.

Over time, the number of plans contracting with OHP has fallen, as has the number of plans per county. The number of counties with only one plan (and thus offer no choice of plan to OHP eligibles) increased from 6 in 1994 to 15 in 1997. Most of these are rural, sparsely-populated counties, where it is unlikely that more than one plan is viable. Although nearly all of the physicians in the community contract with the sole OHP plan, the lack of choice among different health plans could adversely impact rural and small town beneficiaries' access to care.

Impact of the Priority List on OHP Eligibles

Outside Oregon, the use of a priority list to define the OHP benefit package has been highly controversial. Within the State, however, there has been relatively little criticism, as the list is believed to have helped OHP finance its insurance expansion. Nevertheless, to date, there has been no objective information available on how often OHP eligibles may be denied treatment because the service is "below the line" and what impact this has, if any. We conducted a survey of OHP Phase 1 eligibles in 1996, asking them whether they had ever "been told that OHP would not pay for a test, service, or treatment that [they] thought [they] needed." A surprisingly high number (32%) reported "yes." In many instances, these services were not covered, because the respondent had failed to follow managed care rules and procedures (e.g., prior approval for emergency room visits). The most common reason for denial, however, was that the service fell "below the line." About 12 percent of all OHP eligibles reported that they had needed a below–the-line service that OHP would not cover.

One-half of all eligibles with uncovered services succeeded in getting the service anyway. In the case of below-the-line services, like circumcision of newborns and chiropractic services, individuals paid out-of-pocket. Other types of uncovered services, like ER visits, were more likely to remain unpaid and undoubtedly became bad debts for their providers. In a small number of cases (8%), OHP ended up paying for the service, presumably through a successful appeals process.

Among those eligibles who failed to get the service anyway, the majority (60%) reported that their health had worsened as a result. Such reports were significantly higher in

cases where the service had not been covered because it was below-the-line, such as nicotine patches, hernia repair, and treatment of back pain. While the below-the-line services in question tended to be relatively minor, policymakers should note that the majority of survey respondents who were denied a service indicated that their health had deteriorated. Continued monitoring of access to care seems warranted, especially as the priority list continues to be revised.

The Role of Federally Qualified Health Centers in OHP

Many of Oregon's traditional safety net providers, particularly the Federally Qualified Health Centers (FQHCs), have suffered financially under OHP. Changes in reimbursement and competition with other OHP providers have particularly impacted the FQHCs and the populations they serve. Prior to OHP, FQHCs were eligible for cost-based reimbursement of Medicaid services. Under OHP, their payments are now negotiated directly with the managed care plans, who are not willing to pay these high, cost-based rates. Unlike other state 1115 waiver programs, Oregon chose not to supplement managed care payments with additional funds to make up the shortfall to FQHCs. Through its contracts with managed care plans, OHP has substantially broadened the network of providers available to Medicaid eligibles, and particularly to the expansion population that previously was uninsured. Once they were covered by OHP, some FQHC clients have switched to more mainstream providers.

In order to assist FQHCs and other safety-net providers, the State legislature has authorized a special, one-time financial assistance package of $3.1 million. Applicants must

have local matching funds and use the assistance to continue providing services, while working to develop a stable financial base.